

		FOR OFF USE					

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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041467</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Lyncrest Manor of Aledo</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/01</u> to <u>12/31/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>304 S.W. 12th Street</u> <u>Aledo</u> <u>61231</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Mercer</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(309) 582-5376</u> Fax # <u>(309) 582-2435</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IDPA ID Number: <u>371346156001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>4/1/96</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Michael Kaplan</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>100</u>	Skilled (SNF)	<u>100</u>	<u>36,500</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,500</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>904</u>	<u>904</u>	8
9	SNF/PED					9
10	ICF	<u>17,908</u>	<u>5,918</u>		<u>23,826</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,908</u>	<u>5,918</u>	<u>904</u>	<u>24,730</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.75%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location

Date started 4/1/96

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 2/1/98NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 12 and days of care provided 904Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Lyncrest Manor of Aledo # 0041467 Report Period Beginning: 1/1/01 Ending: 12/31/01**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	118,165	12,733	8,473	139,371		139,371		139,371		1
2	Food Purchase		120,173		120,173		120,173	(3,175)	116,998		2
3	Housekeeping	55,974	8,301		64,275		64,275		64,275		3
4	Laundry	29,473	9,782		39,255		39,255		39,255		4
5	Heat and Other Utilities			75,180	75,180		75,180	48	75,228		5
6	Maintenance	17,303		41,121	58,424		58,424	344	58,768		6
7	Other (specify):*										7
8	TOTAL General Services	220,915	150,989	124,774	496,678		496,678	(2,783)	493,895		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	916,314	32,487	(976)	947,825		947,825	1,496	949,321		10
10a	Therapy			94,894	94,894		94,894		94,894		10a
11	Activities	32,977	3,102	1,326	37,405		37,405		37,405		11
12	Social Services	17,447		1,326	18,773		18,773		18,773		12
13	Nurse Aide Training	27,473		6,933	34,406		34,406		34,406		13
14	Program Transportation			854	854		854		854		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	994,211	35,589	110,357	1,140,157		1,140,157	1,496	1,141,653		16
	C. General Administration										
17	Administrative	65,300		23,489	88,789		88,789	(23,489)	65,300		17
18	Directors Fees										18
19	Professional Services			22,356	22,356		22,356	2,259	24,615		19
20	Dues, Fees, Subscriptions & Promotion			9,769	9,769		9,769	(792)	8,977		20
21	Clerical & General Office Expense	90,151	40,580	25,945	156,676		156,676	8,520	165,196		21
22	Employee Benefits & Payroll Tax			203,425	203,425		203,425	6,919	210,344		22
23	Inservice Training & Education							717	717		23
24	Travel and Seminar			3,646	3,646		3,646	1,540	5,186		24
25	Other Admin. Staff Transportation			3,370	3,370		3,370		3,370		25
26	Insurance-Prop.Liab.Malpractice			43,886	43,886		43,886	87	43,973		26
27	Other (specify):*										27
28	TOTAL General Administration	155,451	40,580	335,886	531,917		531,917	(4,239)	527,678		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,370,577	227,158	571,017	2,168,752		2,168,752	(5,526)	2,163,226		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lynncrest Manor of Aledo

#0041467

Report Period Beginning:

1/1/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			95,437	95,437		95,437	554	95,991			30
31	Amortization of Pre-Op. & Org											31
32	Interest			225,774	225,774		225,774	3,092	228,866			32
33	Real Estate Taxes			19,307	19,307		19,307		19,307			33
34	Rent-Facility & Grounds							3,296	3,296			34
35	Rent-Equipment & Vehicle			7,309	7,309		7,309	1,736	9,045			35
36	Other (specify): ^a											36
37	TOTAL Ownership			347,827	347,827		347,827	8,678	356,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Center:		18,419	8,229	26,648		26,648		26,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify): ^a Nonallowable costs			28,054	28,054		28,054	(28,054)				43
44	TOTAL Special Cost Centers		18,419	91,033	109,452		109,452	(28,054)	81,398			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,370,577	245,577	1,009,877	2,626,031		2,626,031	(24,902)	2,601,129			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467Report Period Beginning: 1/1/01Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Program				3
4 Non-Patient Meals	(1,891)	2		4
5 Telephone, TV & Radio in Resident Room	(2,281)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patient				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(51)	32		10
11 Discounts, Allowances, Rebates & Refund				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,083)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transaction				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(1,235)	43		18
19 Entertainment				19
20 Contributions	(630)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainer				22
23 Malpractice Insurance for Individual				23
24 Bad Debt	(19,805)	43		24
25 Fund Raising, Advertising and Promotion	(2,876)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employee				27
28 Yellow Page Advertising	(144)	43		28
29 Other-Attach Schedule See Page 5A	272			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,724)		\$	30

OHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule	\$		31
32 Donated Goods-Attach Schedule			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	4,822		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 4,822		36
(sum of SUBTOTALS)			
37 TOTAL ADJUSTMENTS (A) and (B)	\$ (24,902)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport		X	\$		38
39					39
40 Gift and Coffee Shop		X			40
41 Barber and Beauty Shop		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Aledo

ID# 0041467

Report Period Beginning: 1/1/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income Offset	\$ (1,284)	2	1
2	To disallow non-allowable dues	(660)	20	2
3	To disallow non-allowable subscriptions	(210)	20	3
4	To offset Donated Income w/ Office Supplies	930	21	4
5	To reverse a credit for agency 'CNA's	1,496	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	272		49

Summary A

12/31/01

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DSI Partners, L.L.C.	100%	Lyncrest Manor of Auburn	Auburn	DSI Management		
(owned 55% by Jerry Neal, and		Lyncrest Manor of Effingham	Effingham	Services, Inc.	Peoria	Management Co.
15% each by Sherry Borum-Neal		Lyncrest Manor of Paris	Paris	DSI Partners of		
Lester Robertson (sold his interest				Ohio, L.L.C.	Peoria	Management Co.
Dec. 2001), and Ronald Magnum)						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	DSI Management Services, Inc.	A	\$ 48	\$ 48	1
2	V	6	Maintenance		DSI Management Services, Inc.	A	344	344	2
3	V	17	Management Fees	23,489	DSI Management Services, Inc.	A		(23,489)	3
4	V	19	Professional Services		DSI Management Services, Inc.	A	2,259	2,259	4
5	V	20	Fees, Subscriptions, & Promotions		DSI Management Services, Inc.	A	78	78	5
6	V	21	Clerical & General Office Exp		DSI Management Services, Inc.	A	7,590	7,590	6
7	V	22	Employee Benefits		DSI Management Services, Inc.	A	6,919	6,919	7
8	V	23	Inservices Training & Education		DSI Management Services, Inc.	A	717	717	8
9	V	24	Travel & Semina		DSI Management Services, Inc.	A	1,540	1,540	9
10	V	26	Insurance-Prop. Liab. Malpractice		DSI Management Services, Inc.	A	87	87	10
11	V	30	Depreciation		DSI Management Services, Inc.	A	554	554	11
12	V	32	Interest		DSI Management Services, Inc.	A	3,143	3,143	12
13	V				A: 100% owned by Jerry Neal				13
14	Total			\$ 23,489			\$ 23,279	\$ *	(210) 14

* Total must agree with the amount recorded on line 34 of Schedule V1

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledc# 0041467Report Period Beginning: 1/1/01Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent-Facility & Grounds	\$	DSI Management Services, Inc.	A	\$ 3,296	\$ 3,296
16	V	35 Rent-Equipment & Vehicles		DSI Management Services, Inc.	A	1,736	1,736
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V				A: owned 100% by Jerry Neal		
39	Total		\$			\$ 5,032	\$ * 5,032

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Aledo # 0041467 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Lester Robertson	Executive VP	Administrative	15.00	60,702	10	26.00	Salary	\$ 21,525	L17, C1	1
2											2
3											3
4											4
5					See attached Schedule 7A						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,525		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

DSI Management Services, Inc.
Administrative Salaries/Hours Allocation
12/31/01

Schedule 7A

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors
Compensation Received From Other Nursing Homes

Name	Lynncrest Manoi of Aledo	Lynncrest Manoi of Auburn	Lynncrest Manoi of Effingham	Lynncrest Manoi of Paris	Out of State Facilities	Total
Lester Robertsor	21,525	15,068	17,220	13,346	15,068	82,227

See Accountants' Compilation Report

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467Report Period Beginning: 1/1/01Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DSI Management Services, Inc.
 Street Address 4239 War Memorial Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 Heat and Other Utilities	Beds	382	7	\$ 183	\$	100	\$ 48	1
2	6 Maintenance	Beds	382	7	1,314		100	344	2
3	19 Professional Services	Beds	382	7	8,631		100	2,259	3
4	20 Dues, & Subscriptions	Beds	382	7	298		100	78	4
5	21 Clerical & General Office Exp	Beds	382	7	28,995		100	7,590	5
6	22 Employee Benefits	Beds	382	7	26,429		100	6,919	6
7	23 Inservices Training & Education	Beds	382	7	2,738		100	717	7
8	24 Travel & Semina	Beds	382	7	5,882		100	1,540	8
9	26 Insurance	Beds	382	7	331		100	87	9
10	30 Depreciation	Beds	382	7	2,116		100	554	10
11	32 Interest	Beds	382	7	12,006		100	3,143	11
12	34 Rent-Facility and Grounds	Beds	382	7	12,590		100	3,296	12
13	35 Rent-Equipment & Vehicles	Beds	382	7	6,630		100	1,736	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 108,143	\$		\$ 28,311	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Carol Fleming		x	Mortgage	\$28,000.00	02/02/98	\$ 2,500,000	\$ 2,106,811	06/02/10	0.0900	\$ 190,024	1	
2	Carol Fleming		x	Building Improvement	\$2,500.00	02/02/98	100,000	0	01/02/02	0.0900	4,363	2	
3	NCS Lease		x	Hardware/Software	\$297.00	10/31/98	17,833	12,859	09/30/03	0.1450	674	3	
4	C & J Leasing Co		x	Internet Lease	\$106.00	10/24/01	2,023	1,888	11/31/03	0.2307	53	4	
5												5	
	Working Capital												
6												6	
7												7	
8								Provider Taxes			1,350	8	
9	TOTAL Facility Related				\$30,903.00		\$ 2,619,856	\$ 2,121,558			\$ 196,464	9	
	B. Non-Facility Related*												
10								Allocated from DSI Partners, L.L.C.			13,075	10	
11								Allocated from Management Company			3,143	11	
12								Miscellaneous Interest			16,235	12	
13								Interest Income Offset			(51)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 32,402	14	
15	TOTALS (line 9+line14)						\$ 2,619,856	\$ 2,121,558			\$ 228,866	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lyncrest Manor of Aledo**# **0041467** Report Period Beginning: **1/1/01** Ending: **12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report	\$	16,736	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2000	\$	18,021	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	1,285	3																			
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	18,021	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.) Rounding			\$	1	6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	19,307	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:		1996 16,187 8	<table border="1"> <tr> <th colspan="3">FOR OHF USE ONLY</th> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2000</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATIONS</td> <td>\$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16
FOR OHF USE ONLY																								
13	FROM R. E. TAX STATEMENT FOR 2000	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATIONS	\$	16																					
	1997 15,598 9																							
	1998 16,262 10																							
	1999 16,736 11																							
	2000 18,021 12																							
Real estate tax accrual is based on 100% of Prior year's tax bill.																								

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467 Report Period Beginning:

1/1/01

Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,378 B. General Construction Type: Exterior Brick Frame Block Number of Stories OneC. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization ☒ (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Patient Care</u>	<u>103,498</u>	<u>1998</u>	<u>\$ 40,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	103,498		\$ 40,750	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lynncrest Manor of Aledo# 0041467

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	100	1998	1973	\$ 2,279,250	\$ 56,981	40	\$ 56,981		\$ 218,428
5									
6									
7									
8									
Improvement Type**									
9	Sign	1996		1,391	93	10	93		518
10	6 air conditioners	1996		4,071	407	10	407		2,229
11	2 air conditioners	1997		1,139	113	10	113		524
12	Boiler	1997		3,620	241	15	241		1,165
13	Alzheimer's Wing	1998		64,445	4,301	15	4,301		15,934
14	Fire Alarm, Wiring	1999		772	51	15	51		132
15	Providence Wing Remodeling	1999		18,509	1,234	15	1,234		3,085
16	Air Conditioner Sleeve	1999		1,880	187	10	187		504
17	Water Heater	1999		696	69	10	69		144
18	Security Locks	2000		4,513	301	15	301		602
19	Water Heater	2000		500	50	10	50		79
20	Air conditioner Sleeve	2000		2,753	275	10	275		394
21	Door Alarm	2000		1,138	114	10	114		141
22	Nurses Call Station	2000		5,277	528	10	528		1,012
23	Electrical Wiring on A/C	2000		669	67	10	67		78
24	Security Alarm/Access Control	2001		2,819	110	15	110		110
25	Beri Plmb/ Repair Roof AC	2001		1,499	42	15	42		42
26	Tristate Sprinkler Heads	2001		717	12	15	12		12
27	Tristate Air Compressor For DR	2001		2,198	12	15	12		12
28	Direct Supply HTG/AC Unit	2001		558	36	10	36		36
29	LR Hyett/Window AC unit	2001		584	23	10	23		23
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,398,998	\$ 65,247		\$ 65,247	\$	\$ 245,204	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number: Lynncrest Manor of Aledo

0041467

Report Period Beginning:

1/1/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 277,723	\$ 29,002	\$ 29,002		10	\$ 104,672	71
72	Current Year Purchases	6,666	211	211		10	211	72
73	Fully Depreciated Assets							73
74	Allocated from Management Company			554	554			74
75	TOTALS	\$ 284,389	\$ 29,213	\$ 29,767	\$ 554		\$ 104,883	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	Van	1996	\$ 9,768	\$ 977	\$ 977		10	\$ 5,617	76
77										77
78										78
79										79
80	TOTALS			\$ 9,768	\$ 977	\$ 977			\$ 5,617	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,733,905	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,437	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,991	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 554	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 355,704	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column f

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: On 12/31/2001, under a foreclosure agreement, this facility reverted back to Carol Fleming.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				3,296			6
7	TOTAL				\$ 3,296			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 3,345 Description: Postage Meter-\$1114; Dishwasher-\$495; Allocated from Management Company \$1,736.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Care	1992 Buick Roadmaster	\$ 475.00	\$ 5,700	17
18					18
19					19
20					20
21	TOTAL		\$ 475.00	\$ 5,700	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2002 \$ _____

13. _____/2003 \$ _____

14. _____/2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input checked="" type="checkbox"/>	HOURS PER AIDE <u> </u>
		HOURS PER AIDE <u>8</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 6,933	\$	\$ 6,933
2	Books and Supplies				
3	Classroom Wages (a)		27,473		27,473
4	Clinical Wages (b)				
5	In-House Trainer Wage (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 34,406	\$	\$ 34,406
10	SUM OF line 9, col. 1 and 2 (c)	\$	34,406		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
(c) For in-house training programs only. Do not include fringe benefit.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C3	hrs	\$	1,003	\$ 65,221	\$	1,003	\$ 65,221	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		13	1,008		13	1,008	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C3	hrs		441	28,665		441	28,665	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescripts				18,419		18,419	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10	Academic Education		hrs							10
11	Exceptional Care Program									11
12										12
13	Other (specify): See Schedule 16A					8,229			8,229	13
14	TOTAL			\$	1,457	\$ 103,123	\$ 18,419	1,457	\$ 121,542	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lynncrest Manor of Aledo
Provider #0041467
12/31/2001

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Eye care	L39, C3		600	
Laboratory	L39, C3		6,494	
Ambulance Service	L39, C3		769	
Urological	L39, C3		366	
Total			8,229	0

See Accountants' Compilation Report

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (10,391)	\$ (10,391)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>98,086</u>)	313,883	313,883	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,525	39,525	6
7	Other Prepaid Expenses	19,442	19,442	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Related Parties</u>	22,588	22,588	9
	TOTAL Current Assets			
10	(sum of lines 1 thru 9)	\$ 385,047	\$ 385,047	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,750	40,750	13
14	Buildings, at Historical Cost	2,279,250	2,279,250	14
15	Leasehold Improvements, at Historical Cost	105,695	119,748	15
16	Equipment, at Historical Cost	308,210	294,157	16
17	Accumulated Depreciation (book methods)	(355,704)	(355,704)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
	TOTAL Long-Term Assets			
24	(sum of lines 11 thru 23)	\$ 2,378,201	\$ 2,378,201	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 2,763,248	\$ 2,763,248	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 321,875	\$ 321,875	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,888	1,888	29
30	Accrued Salaries Payable	106,254	106,254	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	5,949	5,949	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,021	18,021	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Parties</u>	2,770,674	2,770,674	36
37				37
	TOTAL Current Liabilities			
38	(sum of lines 26 thru 37)	\$ 3,224,661	\$ 3,224,661	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,859	12,859	39
40	Mortgage Payable	2,106,811	2,106,811	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44				44
	TOTAL Long-Term Liabilities			
45	(sum of lines 39 thru 44)	\$ 2,119,670	\$ 2,119,670	45
	TOTAL LIABILITIES			
46	(sum of lines 38 and 45)	\$ 5,344,331	\$ 5,344,331	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,581,083)	\$ (2,581,083)	47
	TOTAL LIABILITIES AND EQUITY			
48	(sum of lines 46 and 47)	\$ 2,763,248	\$ 2,763,248	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,211,292)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,211,293)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(369,790)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (369,790)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,581,083)	24 *

Operating entity only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Lynncrest Manor of Aledo

0041467

Report Period Beginning: 1/1/01

Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,095,505	1
2	Discounts and Allowances for all Levels	(66,061)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,029,444	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	166,936	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 166,936	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement	6,853	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,891	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,628	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory	9,698	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,386	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 59,456	23
D. Non-Operating Revenue			
24	Contributions	(930)	24
25	Interest and Other Investment Income**	51	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (879)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	1,284	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,284	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,256,241	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	496,678	31
32	Health Care	1,140,157	32
33	General Administration	531,917	33
B. Capital Expense			
34	Ownership	347,827	34
C. Ancillary Expense			
35	Special Cost Centers	54,702	35
36	Provider Participation Fee	54,750	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,626,031	40
41	Income before Income Taxes (line 30 minus line 40)**	(369,790)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (369,790)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity files as a part of a combined cash basis return.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lyncrest Manor of Aledo# 0041467Report Period Beginning: 1/1/01Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,096	2,196	\$ 42,719	\$ 19.45	1
2	Assistant Director of Nursing	607	607	7,309	12.04	2
3	Registered Nurses	6,480	6,924	118,503	17.11	3
4	Licensed Practical Nurses	12,458	13,530	188,840	13.96	4
5	Nurse Aides & Orderlies	52,695	56,440	496,244	8.79	5
6	Nurse Aide Trainees	4,052	4,052	27,473	6.78	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,197	1,373	12,688	9.24	8
9	Activity Director	4,369	4,778	32,977	6.90	9
10	Activity Assistants					10
11	Social Service Worker	1,937	2,143	17,447	8.14	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,778	16,995	118,165	6.95	15
16	Dishwashers					16
17	Maintenance Worker	1,821	1,971	17,303	8.78	17
18	Housekeepers	8,277	8,982	55,974	6.23	18
19	Laundry	4,597	4,871	29,473	6.05	19
20	Administrator	2,080	2,193	43,775	19.96	20
21	Assistant Administrator					21
22	Other Administrative	513	545	21,525	39.50	22
23	Office Manager					23
24	Clerical	5,332	5,476	90,151	16.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,068	1,218	10,267	8.43	31
32	Other Health C: <u>See Schedule 20A</u>	3,421	3,459	39,744	11.49	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	128,778	137,753	\$ 1,370,577 *	\$ 9.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	174	\$ 8,473	L1, C3	35
36	Medical Director	monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	164	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,326	L11, C3	44
45	Social Service Consultant	23	1,326	L12, C3	45
46	Other(specify) <u>Psychological Consult</u>	6	356	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	226	\$ 17,645		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	Lynncrest Manor of Aledo
PROVIDER #	0041467
Period Ending	12/31/01

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
QMRP	2,080	2,080	22,156	\$ 10.65	10
Ancillary Clerk	908	946	6,928	\$ 7.32	10
Care Plan Cord.	433	433	10,660	\$ 24.62	10
Total Line 32 - Other Health Care	3,421	3,459	\$ 39,744	\$ 11.49	

See Accountants' Compilation Report

Facility Name	Lynncrest Manor of Aledo
PROVIDER #	0041467
Period Ending	12/31/01

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	22,356
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Allocated from Management Company	2,259
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Total (agree to Schedule V, line 19, column 8)	<u>24,615</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005	14 FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number <u>Lynncrest Manor of Aledo</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount <u>Illinois Health Care Association \$5872</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>Yes</u> If YES, have these costs been properly adjusted out of the cost report? <u>Yes</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>n/a</u></p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 Yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. <u>1,823</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease <u>n/a</u></p> <p>(9) Are you presently operating under a sublease agreement? YES <u>x</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO <u>x</u> If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over: <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. <u>54,750</u> This amount is to be recorded on line 42 of Schedule V</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? <u>No</u> If YES, attach an explanation of the allocation</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0041467</u> Report Period Beginning: <u>1/1/01</u> Ending: <u>12/31/01</u> Page 23</p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services if the patient census listed on page 2, Section B <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount \$ <u>1,891</u></p> <p>(16) Travel and Transportation</p> <p>a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation</p> <p>b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such program during this reporting period. \$ <u>n/a</u></p> <p>c. What percent of all travel expense relates to transportation of nurses and patients? <u>20</u></p> <p>d. Have vehicle usage logs been maintained? <u>adequate records are maintained</u></p> <p>e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u></p> <p>f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>Yes</u></p> <p>g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period \$ <u>n/a</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>n/a</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>n/a</u> If no, please explain <u>n/a</u></p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees</p>
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SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	118,165	12,733	8,473	139,371	0	139,371	0	139,371
2. Food Purchase	0	120,173	0	120,173	0	120,173	-3,175	116,998
3. Housekeeping	55,974	8,301	0	64,275	0	64,275	0	64,275
4. Laundry	29,473	9,782	0	39,255	0	39,255	0	39,255
5. Heat and Other Utilities	0	0	75,180	75,180	0	75,180	48	75,228
6. Maintenance	17,303	0	41,121	58,424	0	58,424	344	58,768
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	220,915	150,989	124,774	496,678	0	496,678	-2,783	493,895
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	916,314	32,487	-976	947,825	0	947,825	1,496	949,321
10a. Therapy	0	0	94,894	94,894	0	94,894	0	94,894
11. Activities	32,977	3,102	1,326	37,405	0	37,405	0	37,405
12. Social Services	17,447	0	1,326	18,773	0	18,773	0	18,773
13. Nurse Aide Training	27,473	0	6,933	34,406	0	34,406	0	34,406
14. Program Transportation	0	0	854	854	0	854	0	854
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	994,211	35,589	110,357	1,140,157	0	1,140,157	1,496	1,141,653
17. Administrative	65,300	0	23,489	88,789	0	88,789	-23,489	65,300
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	22,356	22,356	0	22,356	2,259	24,615
20. Fees, Subscriptions & Promotion	0	0	9,769	9,769	0	9,769	-792	8,977
21. Clerical & General Office	90,151	40,580	25,945	156,676	0	156,676	8,520	165,196
22. Employee Benefits & Payroll	0	0	203,425	203,425	0	203,425	6,919	210,344
23. Inservice Training & Education	0	0	0	0	0	0	717	717
24. Travel and Seminar	0	0	3,646	3,646	0	3,646	1,540	5,186
25. Other Admin. Staff Trans	0	0	3,370	3,370	0	3,370	0	3,370
26. Insurance-Prop.Liab.Malpractice	0	0	43,886	43,886	0	43,886	87	43,973
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	155,451	40,580	335,886	531,917	0	531,917	-4,239	527,678
29. Total General Administrative	1,370,577	227,158	571,017	2,168,752	0	2,168,752	-5,526	2,163,226
30. Depreciation	0	0	95,437	95,437	0	95,437	554	95,991
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	225,774	225,774	0	225,774	3,092	228,866
33. Real Estate	0	0	19,307	19,307	0	19,307	0	19,307
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,296	3,296
35. Rent - Equipment & Vehicles	0	0	7,309	7,309	0	7,309	1,736	9,045
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	347,827	347,827	0	347,827	8,678	356,505
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	18,419	8,229	26,648	0	26,648	0	26,648
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	54,750	54,750	0	54,750	0	54,750
43. Other (specify):*	0	0	28,054	28,054	0	28,054	-28,054	0
44. Total Special Cost Ce	0	18,419	91,033	109,452	0	109,452	-28,054	81,398
45. Grand Total	1,370,577	245,577	1,009,877	2,626,031	0	2,626,031	-24,902	2,601,129

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-10,391	-10,391
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	313,883	313,883
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	39,525	39,525
7. Other Prepaid Expenses	19,442	19,442
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	22,588	22,588
10. Total current assets	385,047	385,047
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	40,750	40,750
14. Buildings, at Historical Cost	2,279,250	2,279,250
15. Leasehold Improvements, Historical Cost	105,695	119,748
16. Equipment, at Historical Cost	308,210	294,157
17. Accumulated Depreciation (book methods)	-355,704	-355,704
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	2,378,201	2,378,201
25. Total Assets	2,763,248	2,763,248
CURRENT LIABILITIES		
26. Accounts Payable	321,875	321,875
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,888	1,888
30. Accrued Salaries Payable	106,254	106,254
31. Accrued Taxes Payable	5,949	5,949
32. Accrued Real Estate Taxes	18,021	18,021
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,770,674	2,770,674
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	3,224,661	3,224,661
LONG TERM LIABILITES		
39. Long-Term Notes Payable	12,859	12,859
40. Mortgage Payable	2,106,811	2,106,811
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,119,670	2,119,670
46. Total Liabilities	5,344,331	5,344,331
47. Total Equity	-2,581,083	-2,581,083
48. Total Liabilities and Equity	2,763,248	2,763,248

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,095,505
2. Discounts and Allowances for all Levels	-66,061
Subtotal - Inpatient Care	2,029,444
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	166,936
7. Oxygen	0
Subtotal - Ancillary Revenue	166,936
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	6,853
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,891
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	27,628
18. Sale of Supplies to Non-Patients	0
19. Laboratory	9,698
20. Radiology and X-Ray	0
21. Other Medical Services	13,386
22. Laundry	0
Subtotal - Other Operating Revenue	59,456
24. Contributions	-930
25. Interest and Other Investments Income	51
Subtotal - Non-Operating Revenue	-879
27. Other Revenue (specify):	1,284
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,284
30. Total Revenue	2,256,241
31. General Services	496,678
32. Health Care	1,140,157
33. General Administration	531,917
34. Ownership	347,827
35. Special Cost Centers	54,702
35. Provider Participation Fee	54,750
37. Other	0
40. Total Expenses	2,626,031
41. Income Before Income Taxes	-369,790
42. Income Taxes	0
43. Net Income or Loss for the Year	-369,790

Page

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10 Attachment of Real Estate Bill and fill out form

11

12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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23

RECONCILIATION REPORT

Lynncrest Manor of Alex

03:20 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-24,902	equal to	-24,902	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	228,866	equal to	228,866	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,307	equal to	19,307	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	95,991	equal to	95,991	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,296	equal to	3,296	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	9,045	equal to	9,045	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	34,406	equal to	34,406	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	94,894	equal to	94,894	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	18,419	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	496,678	equal to	496,678	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,140,157	equal to	1,140,157	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	531,917	equal to	531,917	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	347,827	equal to	347,827	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	54,702	equal to	54,702	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	54,750	equal to	54,750	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	863,882	equal to	916,314	-52,432	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	27,473	< or = to	27,473	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	32,977	equal to	32,977	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,447	equal to	17,447	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	118,165	equal to	118,165	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	17,303	equal to	17,303	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	55,974	equal to	55,974	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	29,473	equal to	29,473	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	65,300	equal to	65,300	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	90,151	equal to	90,151	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,370,577	equal to	1,370,577	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	8,473	< or = to	8,473	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	164	< or = to	-976	1,140	FAILED	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	1,326	< or = to	1,326	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,326	< or = to	1,326	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched. - Admin. Salar.	65,300	equal to	65,300	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched. - Admin. Other	23,489	equal to	23,489	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched. - Prof. Serv.	22,356	equal to	22,356	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched. - Benefit/Taxes	210,344	equal to	210,344	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched. - Sched of dues..	8,977	equal to	8,977	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched. - Sched. of trav	5,186	equal to	5,186	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	54,750	equal to	54,750	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	6,919	-6,919	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	6,919	-6,919	FAILED	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	27,473	equal to	27,473	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	904	equal to	904	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	4,822	equal to	4,822	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	2,121,558	equal to	2,121,558	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	18,021	equal to	18,021	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,750	equal to	40,750	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,398,998	equal to	2,398,998	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	294,157	equal to	294,157	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	355,704	equal to	355,704	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-2,581,083	equal to	-2,581,083	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-369,790	equal to	-369,790	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..i	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,763,248	equal to	2,763,248	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1